DELTA DENTAL®

Addition of Dentist Form

Complete this form in its entirety and **email it to ProviderRelations@deltadentalva.com** or fax it to 540.491.9709.

1. Demographics

Name of new dentist _____

Dental License Number_____Type 1 Individual NPI _____

Tax ID Number_____Type 2 Facility NPI _____

Office Address _____

Gender _____ Date of birth _____ /_____ /_____

Name of specialty, if applicable_____ Start Date _____ /_____ /_____

Does the dentist wish to participate with Delta Dental at this facility? ☐ Yes ☐ No

☐ Delta Dental Premier® ☐ Delta Dental PPO™ ☐ DeltaCare®

2. Additional Locations

Are there additional locations where the new dentist will be working? ☐ Yes ☐ No
If so, then indicate the locations and the products they will participate in:
(Use a separate sheet to list more locations, if necessary.)

Address_____ Tax ID_____ Start Date ____ /____ /____
☐ Delta Dental Premier ☐ Delta Dental PPO ☐ DeltaCare

Address_____ Tax ID_____ Start Date ____ /____ /____
☐ Delta Dental Premier ☐ Delta Dental PPO ☐ DeltaCare

Address_____ Tax ID_____ Start Date ____ /____ /____
☐ Delta Dental Premier ☐ Delta Dental PPO ☐ DeltaCare

3. Remove from Locations

Are there locations the new dentist is no longer practicing at? ☐ Yes ☐ No

Address_____ Tax ID _____

Address_____ Tax ID _____

Address_____ Tax ID _____

_____ _____/_____/_____
Dentist signature Date